Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Victory Healthcare

Respondent Name
Twin City Fire Insurance Co

MFDR Tracking Number
M4-15-0777-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "(Claimant) was admitted to Victory Medical Center – East Houston on February 4, 2014 for a Lumbar RFTC, Pulse Rhizotomy, CPT code 62282 for 3 levels – L4, L5, and S1. Authorization was obtained for the procedures… Each denial has stated this claim processed and paid correctly the first time. I don't understand how this claim could process that way."

Amount in Dispute: $3,111.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In response to the disputed charges for CPT code 62282, which was billed three times, the carrier first received the operative report with notification of request for medical fee dispute resolution. A medical audit of that documentation revealed that the radiofrequency ablation of spinal nerves. The proper CPT coding for what was actually done would be 64635-36 x 2 or 64640 x 3."

Response Submitted by: Qmedtrix, 8909 SW Barbur Blvd, Suite 250, Portland, OR 97219

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2014	Outpatient Hospital Services	$3,111.66	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – Payment adjusted because the benefit for this service in included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W1 – Workers compensation state fee schedule adjustment
   - OMU01 – Exceeds number of units allowed for this procedure/service
   - 193 – Original payment decision is being maintained

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - The carrier allowed $3,068.64 for procedure code 62282 which has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0203, which, per OPPS Addendum A, has a payment rate of $1,545.07. This amount multiplied by 60% yields an unadjusted labor-related amount of $927.04. This amount multiplied by the annual wage index for this facility of 0.9884 yields an adjusted labor-related amount of $916.29. The non-labor related portion is 40% of the APC rate or $618.03. The sum of the labor and non-labor related amounts is $1,534.32. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $1,534.32. This amount multiplied by 200% yields a MAR of $3,068.64. Carrier's payment is supported.
   - Procedure code 62282 has a description of "Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions,) with or without other therapeutic substance; epidural, lumbar, sacral." Review of the submitted medical documentation finds that this procedure code is not supported as billed.
   - Procedure code 62282 has a description of "Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions,) with or without other therapeutic substance; epidural, lumbar, sacral." Review of the submitted medical documentation finds that this procedure code is not supported as billed.
3. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		January , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.